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A Medical Student of the 90's

By Samuel James Elkin, M.D. (Graduate of 1894)

My first acquaintance of the old Medical College was in 1891 when I met R. L. Morrison who was then attending the College. After he was told that I intended to take up the study of Medicine he said "Come up and I will introduce you to the old College." We entered and he took me from one room to another and made running comments as we went along. In one room on the floor where a stove had once stood, there were evident a lot of gashes from one to three or four inches long. He remarked "This is the way they used to do dissecting, but they do it a little different now." I cannot recall his other remarks on room and equipment, etc., but after our round of inspection was completed he proceeded to give me a bit of advice. He said "Elkin, you take my advice and pick out a wise, steady student, for a room mate, because if you are rooming with one that runs about and does not keep at his studies, why, you will do the same thing, and you won't get along. You know a man is as imitative as a monkey." I thought it good advice and remembered it.

When the late Dr. J. O. Todd was a final year student, attending classes in the old College at the corner of McDermot Avenue and Kate Street, a little insignificant looking man entered the College between lecture hours when the students were walking around between class rooms. Mr. Todd was strutting about with the others when this bashful little man entered the building. Mr. Todd stepped up to him and asked if there was anyone he wished to see. He answered "No, no one in particular." Next question followed, "Are you thinking of studying Medicine?" No, he had not been thinking of studying Medicine. "Then," said Todd "and is there anything I can do for you?" The gentleman did not smile or raise his head, but said, "Yes, if you will find out if Dr. Brett's class is ready, I am going to lecture to them on Surgery, I am Dr. Neilson." Mr. Todd, somewhat abashed, then went and told the class and took his seat, rather embarrassed, with the others of the class, and listened to the little doctor expound for an hour on the mysteries of Surgery as they were understood at that time.

About the year 1892 Winnipeg had a few telephones installed. The General Hospital had one telephone. It was on a party line. One ring called the General Hospital, two rings was the Medical College, and three rings was the Women's Home on McDermot Avenue. One of the students, Mr. A. R. Baird, took great amusement in taking down the receiver and putting it to his ear when the line was being used by others, and he would sometimes carry on a running conversation. One time the telephone rang calling central, but he got there before central. Someone asked for the Hudson's Bay. He answered "This is the Hudson's Bay speaking." "Well, I want the liquor department." He answered "This is the liquor department." "This is the Women's Home calling, and that consignment of liquor we ordered a few days ago has not been delivered." "We sent it out two days ago." "Well, where did you send it to?" Answer: "We sent it to the Medical College." "Oh that was a mistake." "It was a mistake, but they did not come over for it."

One evening A.R. called up the late E. L. Drewry's office and asked for Mr. Drewry. When Mr. Drewry responded, A.R. asked him if he had ever thought of sending up a few cases of liquor for the students. He had never thought of such a thing. "Well," A.R. said, "they would appreciate it very much." But E.L. could not see it in that light, and the matter dropped.

A.R. would frequently call up the girls at Central and carry on amusing conversations with them. He interrupted the telephone service so often that the company removed the telephone from the college, and, only after the faculty agreed to keep the faculty room locked to the students, and that only the faculty should have access to the telephone, did they reinstall the instrument.

At that time some classes of students went over to St. Boniface Hospital for lectures and clinics. One day we were put into a small room at the hospital to wait until the lecture room was ready. A.R. spied a telephone, and of course could not resist the temptation. He put it to his ear, and when Central said "Number", he said: "Do you know my voice?" She said "No." "Well, I will say something and see if you do not recognize me." He then took a long bugle out of his pocket and gave a blast or two into the 'phone. The noise that he made and our laughter made further conversation inaudible.

In those days our class was about 30, and no street cars ran to St. Boniface Hospital, and the faculty thought it too far for the class to walk, so they engaged a large two-horse sleigh to call for us at the College, take us over, and wait there till the lecture was over and bring us back. The only bridge over to

St. Boniface then was the continuation of the present Broadway, and there was generally a man on the bridge to collect toll. We could cross on the ice without toll, but we had to get out and walk up the steep river bank, as the horses were not able to pull up the sleigh when we were in it. The toll collector was an old Irishman, and we used to annoy him. Sometimes we would drive past him and ignore him. He would then get in front of the horses and catch them by the lines. We would say, "Here is the money," and when he would let go and come back for it we would drive off, and leave him by no means silent. One day on the way back from St. Boniface he got in the sleigh to collect from us, and we held on to him while the driver took us back to the College. We then let him go and he had to walk all the way back to the bridge. Another day, when we crossed the bridge, it was clear that the man was away home having lunch. We did not have to pay toll, but when he came back he knew we had crossed, because we stopped long enough to block up the bridge with planks and anything movable we could get, to completely obstruct traffic. Some thoughtful student proposed that we had better go back by the ice that day, and we did.

In those days there was a girl who was more than part time inmate of St. Boniface Hospital. When clinical material was scarce, she was always available for a lecture or an operation. Her knock-kneed deformities had been corrected and most of her organs had either been removed or transferred to other parts of her anatomy. One day—she evidently had not been operated on that day—she was leaving the hospital and was walking to the city of Winnipeg to do some shopping, or perhaps to visit some friends, when the students in the big sleigh overtook her. They offered to give her a lift over to Winnipeg, and she accepted, but when she returned to the hospital later, on account of some of the nuns having seen her get into the sleigh, she was refused admission to the hospital, until reconciliation had been effected, and after that things went on smoothly as before.

The Glee Club of the College thought it would be nice to rent a piano for the winter months, with the idea that it would be entertaining to have some music between lectures and to fill in when a lecturer failed to turn up. They arranged with a piano firm to have a piano for a stated monthly sum, for the six winter months. The piano was delivered, and things went amicably for a time, but some of the lecturers were absent so frequently and some studious boys found it impossible to study in the music and din that prevailed, so at a meeting, a motion was carried that the piano firm be requested to remove the piano from the College to their premises downtown, and a committee was appointed to interview the piano company. The company officials refused to take the piano back unless the full six months' rent was paid down, but the committee said that the agreement was cancelled and that nothing more would be paid for the use of the piano, and further, in their opinion the piano would last longer on their premises than in the Medical College. The piano officials were no fools, and it is needless to say that the piano was removed from the College at a very early date, and the committee was gratefully discharged.

One day we were to have a surgical demonstration in the College on repair of gunshot wounds in the abdomen. To A. R. Baird was delegated the authority to prepare the material for the demonstration. He brought up his big .44 calibre rifle and several rounds of ammunition to the old College. He loaded up the magazine and went upstairs to the dissecting room. He got up on the dissecting table, and with a foot on each side of a corpse he fired several bullets into and through the abdomen. Before this preparation was instituted, a bodyguard was placed downstairs at the door of the room, beneath the dissecting room, to see that no person entered the room during the performance; and thus avoiding the necessity of having head or brain injuries attended to while the abdominal repairs were being made at the actual demonstration.

One day a book agent entered the College, undid his pack of books and handed them around to the eager students to examine. One walked off with one book, another with another book, and soon the poor man had nothing left but his empty pack. He went from one room to another looking for his books, but could not find any. One student directed him upstairs to the first room on the right at the top of the stairs. He went into this room, it was the dissecting room—and several students were at work dissecting. By this time he was showing signs of losing his temper, but the students did not lose theirs. They jostled him around in a friendly manner, and when they could not collect his books for him they put pieces of dissecting material into his pockets, and pinned a scalp on the back of his coat. He went downstairs to find the janitor, and threatened that if he did not find his books for him he would leave him ready for one of the tables upstairs. The students would not let any harm be done to the old janitor, so put some of the books into the kit and bundled the book agent out into the street. When going down the street he put his hands into some of his pockets and withdrew material that was of no use to him, so he came back and threw it inside the door. Later on, downtown, a policeman told him he had better not be carrying the thing around that was pinned to the back of his coat. A few of his books were lying around the college afterwards, but he did not return to recover them.

In the early 90's, medical and surgical histories, when written at all, were concise and to the point. All extraneous and irrelevant material was ignored or expunged from the records. A typical history by one particularly brilliant student read as follows:

"Woman over 40 years, Icelandic, enlarged abdomen. Diagnosis: Hydatids." And believe it or not, generally with that history the diagnosis was correct in about 99½% of those cases, and that may be considered a good average, even in the present advanced age with modern equipment of laboratories, X-rays, etc.

Some lecturers had a habit of coming a little late and then running over the hour, and especially at 12 o'clock the boys did not like to be late for lunch at boarding houses, so they got an alarm clock and would set it off at the hour, and put it into the lecturer's desk or under the front seat; and of course when that would go off the lecture was over. One day the lecturer was the late Dr. Gray, and the clock was set, but did not seem to be set for the proper time. One of the students slipped up to the front seat to adjust the alarm hands, and it seems he adjusted them too well, for the alarm started when he had the clock in his hands. He tried to smother it, but every few seconds it would rattle out again, and there he had to sit holding on to the buzzer under the desk till the lecture was over. Dr. Gray said that when examination time came along, he had better be careful; however, Dr. Gray was very forgiving, and the episode was dropped completely.

Medical Aspects of Workman's Compensation

By D. J. Fraser, M.D., Chief Medical Officer

Workmen's Compensation Acts were passed to compensate a workman to a limited extent for an injury "arising out of and in the course of his employment." Previous to the advent of Compensation Acts a workman could rarely obtain relief for a disabling injury, and then only after time-consuming and expensive litigation. Flagrant abuses by employers and increasing industrial injuries paved the way for reform. To the employer the Acts give protection against damage suits, and to the workman limited benefits in all cases of injury, even though he could not prove negligence on the part of the employer.

Acts in Canadian provinces are based on an exhaustive study by Chief Justice Sir Wm. Meredith in Ontario, and an Act drafted by him in 1914. He decided that the "nuisance of litigation" should be gotten rid of, and the administration placed in the hands of a Board rather than in the courts. The Manitoba Act, patterned on the above report, was passed in 1916; and remodelled in 1920. Since that date legislation has been kept in step with the times by recommendations of the quinquennial committee. Benefits have been increased and certain occupational diseases have been made compensable.

Our Act is administered by a Board consisting of a full-time Commissioner and two part-time directors.

Our funds come from the employers as assessment on payrolls. We have a premium fund of over a million dollars annually, and our trust funds exceed six million dollars. Trust funds are set aside to take care of future payments to men who are permanently disabled and to dependents of men killed in industry. This fund is actuarily verified every five years.

It is our task to receive the casualties of industry, supply them with the necessary medical attention and endeavor to rehabilitate those permanently disabled, and in the meantime take care of the workmen's dependents. We deal within the neighborhood of sixteen thousand claims a year, and in this connection act as a Court in determining various questions of law and fact. Compliance with the Act by employers is compulsory, not optional. A new employer must file an estimate of payroll before commencing business. Failure to do this makes for individual liability and for the payment of compensation to a workman sustaining injury during the period of default. The right of the injured workman to sue his employer is taken away. Employers are thus protected and the worker assured of compensation at a time when he most needs it, i.e., when his pay cheque ceases.

A workman is not permitted to agree with his employer to waive the benefits of the Act. Neither is an employer permitted to deduct from a workman's wages any part of the assessment levied by the Board. No sum payable as compensation can be assessed or attached, nor is it subject to income tax.

Claims resolve themselves into three main groups:

1. Those obviously compensable.
2. Those obviously not compensable.
3. Those where compensability is obscure or doubtful.

The workman must file a claim, and then we must have a report from the employer and the doctor. Delay in any of these forms means delay in the approval of the claim.

Obviously compensable claims are routinely passed, and if the disability period is evi-

dently of some length, the first cheque is mailed at the end of two weeks. However, if the disability period is estimated by you to be less than two weeks, no payment can be made until you notify us the date the man is able to return to work. Delay in sending this discharge form causes delay in payment and hardship to the workman. Where the disability period is extended, progress reports are necessary, as no payment can be made until medical evidence on his continued disability is on file.

Groups two and three are adjudicated by the Board when the evidence on the file is as complete as possible. If we meet difficulty in gathering the evidence, then delay will occur. It is in these two groups of cases that our main difficulties are found, and where we think some misunderstanding with the medical profession occurs.

When a workman reports to you with some injury or disease, you naturally take a careful history. The normal attitude of our profession to a history is to assist us to arrive at a diagnosis and thus proceed with treatment. We are not acutely interested in the etiology of the trouble at the moment. However, from the standpoint of compensation, we must accept a different concept of etiology. Compensation administration is interested in establishing a claim. Did this condition arise by accident during the course of employment? Clearly, the employer does not want to pay and cannot be expected to pay for something that did not originate in the industrial environment of his place of business. Contrariwise, the workman is certainly entitled to compensation for disability arising out of and in the course of the employment.

Thus your history must be accurate as to the time of occurrence, type of strain or other injury, and the immediate results. On examination, you should look for direct evidence of injury and record it accurately. If limbs are affected, record carefully whether right or left, volar or dorsal surface. If fingers, state index, middle, ring or little; and for phalanges, proximal, middle or distal. The importance of accurate recording becomes very evident when a workman presents himself years later and wishes to establish the relationship between some complaint and some previous injury.

The history you obtain from the patient, together with your examination, should disclose whether or not the disability complained of is one arising out of his employment. In the group one class, this is self-evident, but in groups two and three, their relationship is not always clear. In the latter cases, your opinion written on your first report is of inestimable value to the Board in adjudicating the claim. This is particularly so when you are the family physician, and the claimant's previous medical history as well as personal history is known to you.

When you send in our first form without expressing an opinion to the contrary, we must assume you are supporting the claim; a claim against the workman's employer which may amount to many thousands of dollars. Detailed findings of examination, operation and X-ray interpretations must be on our file, as cases may be reviewed at any time by a Medical Board, and a clear picture must be presented at this time. Do not endeavor to discourage the patient from filing a claim, if he so desires; that is his right, and he will be better satisfied if he does so. Just state your opinion on your report and the responsibility for rejection will be taken by the Board. Always remember that his claim is outlawed if not filed within one year from the date of accident.

Many difficulties arise in dealing with claims for diseased conditions developing subsequently to injuries. The claimant quite honestly believes that the disease which ensues is the direct result of his injury, whether the latter was recent or several years previously. In these cases a reasonable chain of causation between the injury and the onset of disease must be shown. It is not sufficient that the disease alleged to be a sequel may be and often is a consequence of injury. It must be established to be so in the particular case under review. or at least the weight of probability, rather than possibility, warrants the inference that a casual relationship exists.

Where sequelae may be due to several causes, one of which is industrial injury, the onus is upon the claimant to prove that in fact the sequelae were caused by the injury and not merely that they might have been. To establish any causal relation between the accident and sequelae, there must be a direct sequence or chain of events. When an interval of recovery occurs, the presumption is against the causal connection.

When claims are accepted, our next interest is, "When does the disability end?" Ordinarily, this is interpreted as complete recovery and the workman is able to resume his regular employment. However, in many cases complete recovery is not attained, and some permanent disability remains, or the man may be able to resume some lighter form of employment while waiting for complete recovery. Thus, we have what is termed temporary partial disability. In such cases, the Board may assess the workman with an earning capacity and thereby reduce his compensation, or, if he is able to do lighter work at a reduced income, two-thirds of his wage loss is paid. Your progress reports should indicate when you think the workman could assume light work, or reduced hours at his regular work.

Speaking of a workman's earning capacity, it would, perhaps, not be out of place at this time to mention a problem that gives us much

concern. A workman sustains what is apparently a not-too-serious injury. He claims that he suffers from pain and is unable to work. It may be well-nigh impossible for the medical man to prove or disprove his contentions. Let us assume that we accept his word and permit him to remain off work and on full compensation. Over the years, we have found so many of such cases deteriorate mentally to the extent that it is absolutely impossible to again get them to make any useful endeavors. On the other hand, it would appear sometimes cruel to dismiss their complaints and cut them off compensation. The question arises as to whether it is not in the best interests of the workman to take what appears on the surface as a harsh attitude—insist that they go back to work, and cut them off compensation. Experience has shown that in many cases a workman, after a period of employment under, ofttimes, distressing conditions, has been able to eventually overcome his trouble and has become an asset to the community. Sometimes, it takes a short period, and again it may take a long time. We all know from experience that in private practice, where there is no element of possible compensation or prospective damage action in Court, the patient so often overcomes his troubles, returns to useful employment and again becomes self-supporting. It should be borne in mind that if time and experience should indicate that the workman is definitely disabled, the matter can be readily rectified.

The point I am endeavoring to suggest is that neither the Board nor the doctor is doing the workman a favor by encouraging fear or malingering, whether or not it is deliberate or intentional on the part of the patient. A few extra weeks', or even months' compensation may seem a kind gesture to the claimant, but it may be the opposite. I would like to impress upon you the extreme importance of this matter. Over the years, the problem has so often been brought home to us, and the problem initially and mainly belongs to the attending physician. If he tells the patient that his working days are over (and we have such cases), or if he encourages or permits a pessimistic attitude, then it is almost impossible for the Board to inspire in the workman any effort or ambition. It is suggested that in many cases it may be to the workmen's best interests for you and the Board to take what may seem a harsh and cruel attitude. This will take courage; it will invite criticism; but experience has shown that it is ofttimes well worthwhile in the patient's interests.

Where permanent partial disability results from the injury, an assessment of this disability is made in terms of earning capacity. A schedule for rating permanent disabilities is given on page eight of the Surgical Fee Schedule. Where loss of limb, or part thereof, occurs, the assessment is an easy matter; but where only impairment results, wide differences of opinion may be held among medical men as to the percentage of disability. In these cases, frequent reference is made to the Medical Board of Review for an unbiased opinion. When the permanent partial disability is 10% or less, a Lump Sum Settlement is frequently offered the workman. If accepted, he can have no subsequent claim in reference to this particular injury. Where the disability is over 10%, a monthly pension is payable for life, but only if his earning capacity is less than at the time of injury or he is unable to obtain employment due to his disability. Not infrequently, the Board will assist the workman to train himself for an occupation within his capacity.

Last, if not least, comes your remuneration for services rendered. In this connection, I would draw your attention to the booklet we publish, giving general information as to the rendering of accounts and our Schedule of Fees. A large percentage of the reductions in your accounts are due to insufficient information on the file or the amount of the account exceeds the schedule rates. All accounts must be rendered within six months from the date of the last attendance, or they automatically become outlawed and cannot be paid.

Personal Notes and Social News

Captain G. E. Wakefield, R.C.A.M.C., and Mrs. Wakefield are receiving congratulations on the birth of a son (William David) on October 21st, 1944, at the Winnipeg General Hospital.

♦

Colonel Percy G. Bell, D.S.O., has retired as officer commanding the Fort Osborne Military Hospital.

♦

Major C. B. Schoemperlm, R.C.A.M.C., has been promoted to the rank of Lieut.-Colonel.

Lieut.-Colonel Ross Henry Cooper, R.C.A.M.C., (Overseas) has been promoted to the rank of Colonel.

♦

Lieut.-Colonel Thomas Edward Holland, R.C.A.M.C., (Overseas) has been promoted to the rank of Colonel.

♦

Dr. and Mrs. Walter Alexander are happy to announce the birth of a daughter on November 24th, 1944, at the Winnipeg General Hospital.

Case Report

Report on a Case of Congenital Valvular Obstruction of the Upper Jejunum

By P. H. T. Thorlakson, M.D., C.M. (Man.), M.R.C.S. (Eng.), F.R.C.S. (Can.)

The conditions responsible for intestinal obstruction due to congenital anomalies in infants and older children are well known. The case which is described is one where an intrinsic type of lesion caused interference with the continuity of the lumen of the bowel. The development of such a condition must depend upon the events which occur in the intestine during early embryological life. Before the fifth week the fetal bowel is represented by a well-defined hollow tract lined by epithelium. During the four or five weeks that follow a very marked proliferation of this cellular layer occurs. So profuse is this activity that the lumen becomes occluded throughout its length by a solid column of tissue. However, after the tenth or twelfth week this apparent consolidation is rendered vacuolar and the patency of the intestine is resumed. Occasionally, and it is extraordinary that it occurs so infrequently, this resolution is not complete. The result is that plugs of cells may

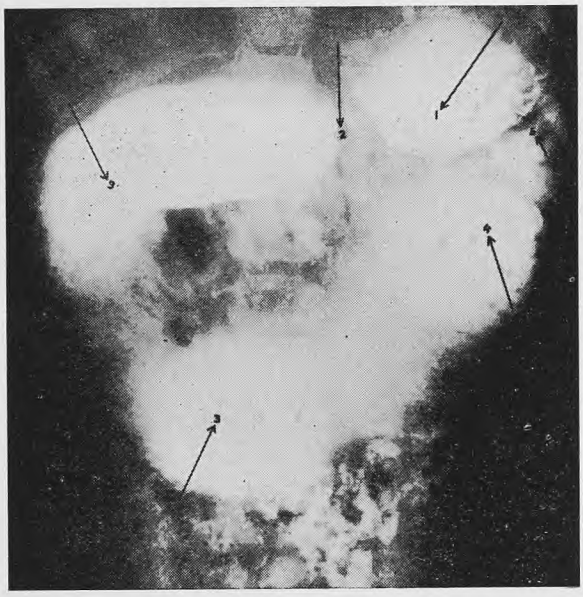

Plate taken and diagnosis made at Children's Hospital, Winnipeg

1. Stomach.
2. Pylorus.
3. Duodenum.
4. Dilated Proximal Jejunum.
5. Stricture.

persist capable of producing complete or incomplete obstruction. These surviving masses of cells may vary not only in their site but also in the length of bowel involved. Thus it is established that the common sites are in the duodenum near the ampulla of Vater, in the ileum close to the site of Meckel's diverticulum and in the lower rectum or anus. However, examples of obstructing causes of this nature have been noted in both the jejunum and ileum at variable levels. Such occlusions may be due to a solid block of tissue or a simple membrane which may be complete or only partial.

Attention has been drawn to the possible difficulty in differentiating cases of partial or incomplete small bowel obstruction of this type from cyclic or periodic vomiting. Both conditions occur in young children and may have been present for months or years. In the interval there may be complete cessation of symptoms. During the attacks, which may continue for a day or a week, vomiting may be severe and nothing can be maintained on the stomach. So severe may the vomiting be that dehydration and alkalosis result. However, pain is not a common symptom in cyclic vomiting. Intussusceptions in children rarely resolve themselves and thus there is rarely a history of recurrent attacks. Vomiting and pain of sudden onset in a child of a few weeks to two to three years of age, where the pain is colicy and intermittent with intervals of relief, warrant a careful examination of the abdomen. If in addition to the colicy pain and a mass there is bloody discharge from the rectum and a mass is palpable by rectum the diagnosis is substantiated.

The patient was a male child age three years. His complaints consisted of abdominal pain and recurrent spells of vomiting. The history revealed that the child began to vomit when two days old and that part of every feeding had been vomited until the age of four months. Following this there had been some improvement. However, during the past two years, the patient had suffered spells of severe vomiting for periods of two to three weeks. On August 10th, 1943, this reached a climax when, in addition to vomiting large quantities, he developed severe epigastric pain.

On examination the child was found to be undernourished. Marked distention of the upper abdomen was noted. No other physical abnormalities were made out. He was admitted to the Winnipeg General Hospital where gastric suction was instituted. Within twenty-four hours after admission he went into convulsions associated with tetany no doubt due to the vomiting and resulting alkalosis. He promptly recovered from this state after the intravenous administration of sodium chloride solution. A barium meal revealed marked dilatation of the stomach, duodenum and the first part of the jejunum. A diagnosis of obstruction of the upper small bowel likely due to a congenital anomaly was made, based on the long history of sickness and the x-ray findings.

After a suitable course of pre-operative treatment, designed to restore the acid-base ratio, laparotomy was performed on August 24th using ether anaesthesia. The duodenum and first part of the jejunum were enormously dilated, the latter to a point about twelve inches from the duodeno-jejunal juncture. The diameter of the dilated bowel above the site of the obstruction was about five times that of the normal bowel distal to it. The cause of the obstruction was not extrinsic and so not immediately obvious. A longitudinal incision was made through the wall of the bowel at the site of the trouble and an incomplete valve of the mucosa was disclosed. This was excised and the longitudinal incision in the bowel wall, involving both dilated and normal portions, was closed in the opposite direction.

An uneventful recovery followed with cessation of pain and vomiting. On September 30th, five weeks after operation, a barium meal showed stomach and bowel still dilated but definitely improved. A further examination on May 26th, 1944, revealed a normal upper gastro-intestinal tract. The child appeared satisfactory generally. His appetite and food intake were normal and there had been no further vomiting. A gratifying gain in weight had resulted.

Clinical Luncheon Reports

Winnipeg General Hospital

"Group Luncheon," Thursday, November 2, 1944

1. Welcome to Dr. Riggs of Vancouver.

Hearty congratulations to Dr. H. M. Speechly, on passing another milestone.

2. "Syme's Amputation"—Dr. A. Gibson.

Dr. Gibson stated that overseas this operation was uncommon and unpopular for two reasons: First, they wished to use a standardized artificial limb, and second, the Syme's amputation did not stand up under work.

Dr. Gibson cited a man who had a Syme's 20 years ago who had been engaged in heavy occupation for this time, and showed a miner who had an emergency amputation through the metatarsals which was unsatisfactory under heavy work. This patient was admitted to the Winnipeg General Hospital October 9, 1944, and a Syme's amputation was done a few days later. Dr. Gibson showed the patient with a well healed scar, and gave details of the correct way of performing a Syme's; a very important feature is the arterial supply to the stump. Dr. Gibson was of the opinion that the fault with the Syme's amputation is in the operator, not the type of operation.

Dr. Gibson mentioned Lisfranc and Chopart operations.

Dr. D. J. Fraser asked what was the best form of prosthesis. Dr. Gibson thought a bucket type with some sustaining apparatus as high as the knee. Dr. Gibson said this was a man's operation, that it was unsuitable to a female due to the appearance.

3. "Septic Abortion Treated with Penicillin"—Dr. J. D. McQueen.

Dr. McQueen stated that there were four deaths in eight years following septic abortions. Of these four, two deaths were within 48 hours and both had B. Welchi.

Mrs. ————, aged 25, was admitted to the Winnipeg General Hospital on October 3, 1944. Her last menstrual period was July 20, 1944. Before admission she had emesis, fever and pain in the abdomen. She had performed a self-induced abortion around September 26, 1944. On admission her pulse was 126, temperature 105, respiration 24, and blood pressure 102/66. White blood cells were 25,000, haemoglobin 70%. She was given sulfathiazole for a couple of days, without any reduction of temperature. Blood culture at this time was positive for anaerobic staphylococcus. At this point the patient passed a macerated foetus. Sulfadiazine was given for 30 hours, with no apparent effect. Penicillin was then started, with reduction in symptoms and pulse, temperature and respirations. She received 725,000 units of Penicillin.

Those taking part in the discussion were Drs. Nicholson, Best and Rennie. The latter mentioned some authors suggested the use of Penicillin and the sulfa drugs as these infections were not always just one organism.

4. "Diabetes Insipidus in a Child." — Dr. H. D. Kitchen.

A little girl, aged 3, brought in 6-7 weeks ago. No past history except occasional discharge from ears. Physical examination negative except moderate seborrhoea of scalp with tendency to small sores. March or April, 1944, developed tremendous thirst and polyuria and had nocturia several times a night. Water intake reached 4,000 ccs. for a few days; output parallel.

X-ray of sella turcica: Dr. McPherson found evidence of bony defects in skull. Xanthomatosis.

Hans - Schuler - Christian's syndrome was diagnosed. This is a lipoid storage disease of reticulo - endothelial cells, pathogenesis unknown. Typical syndrome: Defects in membranous bones; diabetes insipidus; exophthalmos.

Blood cholesterol was a little high. (Mayo's had 8 cases.)

Treatment: (1) Principles — treat diabetes insipidus with pituitary extract. (2) X-radiate bones.

(1) ½ c.c. infundin q. i. d. was given later pitressin tannate (½ c.c. intramuscularly every other day) held balance pretty well. It is supposed to have more lasting effect than infundin. Patient is still on ½cc. every other day.

Retaining catheter was used at first but has been discontinued for past 2-3 weeks; child is wakened once a night now.

Personality change in child is remarkable.

Prognosis — questionable as to cure, but balance can probably be maintained.

Dr. MacPherson:

X-ray Changes: Multiple bony defects in skull, pelvis and occasional long bones.

Areas of sclerosis occasionally surround the osteolytic areas.

Radiation was given to skull; some improvement shown though maximum effect not expected yet. Course of X-ray just finished; defects are less translucent.

Does X-ray affect diabetes insipidus? This point is debatable yet.

Prof. A. T. Cameron:

In this case presumably the diabetes insipidus must be secondary to an abnormal disturbance of lipoids. Diabetes insipidus may be caused by damage to the posterior pituitary or to the nerve paths of the supraocular nuclei. In treatment the use of X-ray unless applied directly to the pituitary gland will probably be of little advantage.

Taking part in the discussion were Dr. A. Gibson, Dr. Charles Hunter and Dr. W. E. Campbell.

RETURN ENGAGEMENT

GLUCOPHYLLINE, an efficient diuretic and myocardial stimulant, has been an important factor in enabling many persons with arteriosclerotic and hypertensive heart disease to return to normal usefulness. Offering two important advantages over theophylline, Glucophylline is both more soluble and more effective, and causes far less gastrointestinal irritation. These special properties result from the fact that Glucophylline is a "double salt"—a combination of theophylline, the most effective of the xanthine group of diuretics, with the mild diuretic, methyl glucamine. Clinical trials have demonstrated that Glucophylline produces a diuresis that compares favorably with that produced by other theophylline compounds in general use. In one series of tests, the average excretion produced by Glucophylline in normal men was 702 cc. as compared with 280 cc. without the drug. Glucophylline tablets contain either 2.34 or 4.68 grains of theophylline-methyl glucamine, representing 1.18 or 2.36 grains of theophylline. The tablets are available in bottles of 20, 100 and 1000. ABBOTT LABORATORIES LIMITED, Montreal 8.

GLUCOPHYLLINE
(THEOPHYLLINE-METHYL GLUCAMINE, ABBOTT)

Glucophylline and Nembutal tablets, containing either 2.34 or 4.68 grains of Glucophylline and ¼ grain of Nembutal, combine the diuretic action of the former drug with the sedative and antispasmodic action of Nembutal. Used in treating certain cases of hypertensive heart disease. Supplied in bottles of 20, 100 and 1000 tablets.

Winnipeg Medical Society—Notice Board

P. H. McNULTY—*President*
A. M. GOODWIN—*Vice-Pres.*

Next Meeting

Friday, December 15th

W. F. TISDALE—*Secretary*
E. S. JAMES—*Treasurer*

Dr. McNulty is anxious that the members know the names of those who assist him in his duties as President of our Society. His principal assistant, the Vice-President, is Dr. A. M. Goodwin. Dr. Walter Tisdale is Secretary, and Dr. E. S. James looks after our wealth. In addition, Drs. C. M. Strong and C. B. Stewart, as Past Presidents, have seats in this Cabinet. There are also three Trustees—Dr. J. E. Tisdale, who retires next year; Dr. I. O. Fryer, who retires the year after, and Dr. Anna Wilson, who will favor us with her presence for three years.

There are seven committees, the personnel of which are appointees of the President. The chairmen are members of the Executive. The first of these committees looks after the Programmes; its Chairman is myself, and for assistants I have Drs. A. T. Gowron and F. G. Allison. The Legislative Committee comes next, and consists of Dr. W. E. Campbell. Dr. B. Dyma presides over the large and important Membership Committee, which consists of Drs. A. M. Goodwin, Henri Guyot, O. C. Trainor, R. Wengel, H. Oelkers, C. S. Hershfield and R. J. Cleave. The Library and Publications Committee has five members—Dr. D. Nicholson, Chairman, and Drs. Goodwin, James, Anna Wilson and W. F. Tisdale. Dr. A. Hollenberg constitutes the Committee on Economics, and Dr. J. E. Tisdale the Public Health Committee. The seventh is not a regular committee, but a temporary one, established in 1940. It is the Overseas Committee. On it we have one member—Dr. Edmison. Two other members, Dr. C. H. A. Walton and Major Harvey McNicholl, represent the Manitoba Medical Association and the College of Physicians and Surgeons, who contribute to the Fund.

Each section of the Society appoints a representative to the Executive. These representatives are: For the Eye, Ear, Nose and Throat Section, Dr. I. H. Beckman; for the Section on Obstetrics and Gynecology, Dr. F. G. McGuinness; for the Medical History Section, Dr. J. C. Hossack. The Hospital Section is represented by Dr. H. F. Cameron.

The President appoints representatives to the Manitoba Medical Association (Dr. F. D. McKenty), the Central Council of Social Agencies (Dr. A. W. Hogg), the City Health Committee (Drs. F. A. Benner and F. G. McGuinness), the Committee of Twelve (Drs. W. E. Campbell, O. C. Trainor, Robt. Black), to Group Hospitalization (Dr. Elinor Black). In addition, Dr. McNulty created a new Committee of Vigilance, of which Dr. J. M. McEachern is Chairman.

The personnel of the Executive and other committees and the representatives, include members of every hospital, district, race and creed. The membership of the Society is thus completely represented in its governing body, which is as it should be.

The second meeting of the Society, like the first, taxed the capacity of our quarters. I was not there, but I imagine by the time it was over, those seated at the back were, like the ancient gods on Mount Olympus, peering red-eyed through the thickening clouds (of smoke) at what was transpiring far below them. Mr. McMurray gave a useful talk, which, I hope, you will have a chance to read in a later issue. Dr. Fraser's paper evoked discussion, which is always a good sign. Dr. Burrell gave the contribution he was supposed to have given last month, and Dr. McEachern, for the second time, generously gave place to the other speakers.

Skin and Bones inspire the December speakers. Drs. Birt and Brock are going to reveal some of the mysteries of skin diseases. (The skin game and all about it, by two who know—that would make a good title.) I think it was Osler who divided skin diseases into three groups—those that mercury would cure, those that sulphur would cure, and those that the Lord Himself couldn't cure. Well, we will see what the firm of Brock and Birt can do.

There is a widespread and enduring belief that skin diseases result from eating the flesh of sacred or tabooed animals. Thus the Egyptians held that eating pig's flesh would cause leprosy. The Omaha Indians will not eat the flesh of the elk for a similar reason, and again, on the same basis, the Syrians avoided fish. In the Celebes the natives will not eat the flesh of their totem animals (serpents, eels, dogs, etc.) lest they become lepers. Let not the modern scientist say that the prohibition was due to a recognition of trichiniasis or allergy, for people of other totems could and did eat the flesh taboo to others without harm. Kinship with the animal was the underlying reason for taboo, and, therefore, eating its flesh was tantamount to cannibalism.

Now I am going to mention a famous cure cure for pimples, introduced or at least publicized by Marcellus, who was physician to the Emperor Theodosius I. Here are his instructions: "Watch for a shooting star and instantly, while the star is still shooting, wipe the pimples with a cloth, and just as the star falls from the sky, so will the pimples fall from your body." Try it sometime.

As for the bones, Drs. James and Deacon are going to discuss fractures especially of the shaft of the femur. Dr. Gibson is going to lead off the discussion.

A small but select audience listened to Dr. K. Johnston's paper on "The Triumphs of Tuberculosis." It was so interesting that he was

urged to submit it to the Journal of the C.M.A. He paid tribute to Bethune, both as a victim of, and victor over, tuberculosis. Bethune was a most enthusiastic advocate of collapse and expressed his convictions amusingly but forcibly in his "Compressionist's Creed", which I append.

The Compressionist's Creed

"I believe in rest the restorer, mighty maker of fibrosis and health, and in artificial pneumothorax, which was conceived by Carson; born of the labours of Forlanini, suffered under pompous pride and prejudice, criticized by the cranks of exercise therapy, whose patients are now dead and buried, defended by thousands now well, who even in the third stage rose again from their beds; these two ascended into the Heaven of Medicine's immortals, and sit on the right hand of Hippocrates our Father, from thence they do judge, those phthisis therapists quick to collapse cavities or dead on their job.

"I believe in Laennec, Bodington, Brehmer, Koch, Trudeau, Freidrich, Stuertz, Jacobaeus; in bilateral pneumothorax, in phrenicectomy, in the cauterization of adhesions; the unforgiveness for sins of omission to collapse cavities; the resurrection of a healthy body from a diseased one, and long life for the tuberculous with care everlasting. Amen."

♦

Two happenings of the October meeting I am reporting at this late date, because I did not have the information in time for last issue. One was the remarkable tribute paid to Dr. F. D. McKenty by Dr. Strong, as the latter introduced him for his Life Membership. I understand that, as if in order to draw attention to Dr. McKenty's specialty, Dr. Strong put on either a genuine epistaxis or a very reasonable facsimile thereof. He didn't, however, proceed to let Dr. McKenty demonstrate his prowess as a haemostatitian, but left the room, presumably to do his bit by the Blood Donors' Clinic.

The second occurrence was none other than a mention of myself and an expression of the wish of the members that I get better quickly. To Dr. Ross Mitchell, who made the motion, and to the audience that seconded it, I can only say thank you; but put yourself in my place, and you will understand how pleased, how grateful and how inarticulate one is made by such spontaneous kindness. J. C. H.

Overseas Letter

Italy, 21st Oct., 1944
(4 Cdn. C.C.S.)

Dear Dr. Hossack:

It is with considerable trepidation that I at last write you after the years now that "The Review" and the parcels from the Winnipeg Medical Society have been coming regularly and on schedule. I did write the Society once—just a year ago now, the last time I was laid up, but subsequently heard that the mail that week was lost and never got round to despatching a duplicate letter. It would seem that the only time that some of us ever get around to writing anything but "essential" letters to our immediate families is when we get laid up for a few days as I am at the moment with a cold, so will you please accept my humblest apologies for this unforgiveable tardiness and convey my most sincere thanks to those others responsible for the regular arrival of said parcels and bulletins—detaching in passing your share of the thanks, which I have an idea is probably in truth the lion's share. The "Review" in particular is appreciated out here—I know I pass on my issue to someone almost every time. The "gossip" column at the back is always of interest and the leading article, of course, is always well worth reading for anyone. It struck me as rather funny one night after a late supper during the tail end of the "Gothic Line" so when I ambled into the mess to find two of the lads involved in a very earnest discussion of Eclampsia which was all started by Dr. Fred McGuinness' article in a recently arrived number—one of the contestants was from Toronto, the other from Vancouver (I think), neither had ever heard of Dr. McGuinness and Winnipeg was just a spot on a dusty stretch of the map to them but they both decided that F. McGuinness maybe knew a thing or two and since then have regularly purloined my copy the first time I lay it down. So you see, your kindness is appreciated by more people than you would suspect and, of course, for those of us who hail from the modest building on Bannatyne Avenue every paragraph holds interest and revives memories.

The worst news from home we have had for a long time, of course, was of "Old Brandy's" death. "The old order changeth . . . " with a vengeance.

Things go on much as usual here — not too rough and tough and the boys keep grinding slowly ahead. As for the work, we see the odd bit of malaria and a fair amount of hepatitis, but amazingly little dysentery — no chests as yet — although they will be starting any day no doubt. Of course, there is always a "teaser" turning up that we can't hold long enough at this level to solve, which is all very annoying.

I suppose you would like a little news of Manitoba people out here for your "scandal sheet," so here goes. Marley Elliot hasn't lost an ounce! He whips around keeping everyone in a perpetual state of hygienic and sanitary perfection and, incidentally, some of his boys have produced gadgets that Chick Sale never even heard of! — By the way, Hartley Smith would probably be interested to hear that his old M.A.C. crew are doing a wonderful job — as a unit they have done an outstanding bit of work from their first show. Mike Carleton I haven't seen for some time — he is president of a standing medical board. Major Guy Curry,

(Continued on Page 368)

Editorial

After half a century one may safely relate the escapades of his youth and, indeed, should do so as a matter of historical interest. It is fifty years since "Sammy" Elkin assumed the title of Doctor. The excerpt from his autobiography in this issue will give our readers several hearty laughs and make them ask for some more of his experiences and reminiscences. Perhaps there are other old-timers who would like to relate the harrowing details of their early lives, and if there be any such we'll be glad to hear from them.

Mills don't run without grist and journals don't flourish in the absence of contributions. The Review, as I have said before, aims at being a family affair, a sort of meeting place where friends get together to swap useful knowledge. Its informality is meant to encourage those who have something to say but have neither the time nor the inclination to write a "heavy" article. There are many of you, both in town and country, who can and should be contributing. Our plans for the future demand more voluntary contributions and it is the duty, especially of those who are active in hospital and university work, to keep us supplied. If the Review is to run smoothly it is essential that we have a backlog or pool of articles to feed into the press. This we do not have, and our task is enormously increased by its absence. I would appreciate it very much if those of you who have promised material would quickly implement your promises. Men in the country also can help. They can, if nothing else, relate their difficulties or suggest what they would like to read in our pages. They have cases to report and perhaps questions for which they would like an answer. We need neither bigger nor better papers, but we do need more of them.

J. C. H.

Letter to the Editor

To the Editor:

Manitoba Medical Service

In his letter in the Manitoba Medical Review (Nov., 1944), Dr. P. H. T. Thorlakson offers criticism and recommendations. These are not to be dismissed lightly. It is not with the idea of engaging in controversy, but with a desire to present the facts of the origin of this medical prepayment scheme that the Board of Manitoba Medical Service offers reply.

During the depression years the Executive of the Manitoba Medical Society, which is organized medicine in Manitoba, set up a committee on Economics. The Firefighters' Club of Winnipeg requested medical care for its members and dependents. Out of this arose in 1940 the Firefighters' Medical Service. Other employed groups requested like service. The M.M.A. Executive instructed its Committee on Economics to prepare a more comprehensive scheme.[1] In November, 1941, the Committee submitted a scheme which was approved by the Executive and ordered to be presented to the profession. A circular letter was sent to practitioners, asking if they approved the principle. The reply was almost unanimously in favor. As the scheme was to be tried out first in Winnipeg, an invitation was sent to each practitioner in Greater Winnipeg to attend a meeting on December 12, 1941. At this meeting the principle of two plans was adopted, one giving limited surgical coverage, the other complete coverage. In January, 1942, the M.M.A. Executive authorized its President to name provisional Directors.[2]

Many meetings of the Directors were held, with the late Mr. W. C. Hamilton, K.C., to draft the by-laws necessary for incorporation and the contracts. To the eight Medical Directors were added seven lay Directors: Mr. M. D. Grant, Sovereign Life Assurance Co.; Mr. F. W. Ross, Bank of Nova Scotia; Mr. E. Jones, Bank of Montreal; Mr. R. W. McKay, Allan, Killam & McKay, Ltd.; Mr. John B. Richardson; Mr. D. H. Murdoch; Mr. Donovan Swailes, then Secretary of the Trades and Labor Council. These gentlemen gave valuable advice. Dr. Moorhead was in communication with H. H. Wolfenden, consulting Actuary of the Canadian Medical Association. The Board had the experience of similar schemes in Canada and the United States, particularly as to rates.

The forms of contracts were laid before another special meeting of the doctors of Greater Winnipeg on October 30, 1942. Eight additional Medical Directors were appointed, and vexatious problems of fees, etc., were discussed and agreement reached. Again the profession was invited to send in comments and criticisms, which were reviewed. Late in September, 1944, almost three years after the scheme was first set before the profession, the sale of contracts was begun by Manitoba Hospital Service Association as agents for Manitoba Medical Service.

Articles on Manitoba Medical Service appeared in the Manitoba Medical Review and Canadian Medical Association Journal.[4]

With these facts before one it is hard to convict the M.M.A. Executive or the Manitoba Medical Service Board with being unduly precipitate or being unaided by any expert with experience or special knowledge of insurance principles.

In his printed report to the 1944 meeting of Manitoba Medical Association the Chairman of the Manitoba Medical Service Board stated: "Your Committee has attempted to interfere as little as possible with present professional practice, but simply to act as intermediary between the patient and the doctor in their financial relationship."[5]

Manitoba Medical Service has been underwritten by $5,000.00 from the College of Physicians and Surgeons, $1,000.00 from Manitoba Medical Association, and $500.00 from Winnipeg

Medical Society. In 1942, 130 Winnipeg physicians signed notes of $100.00 each, and since then others have signed.

Manitoba Medical Service is not a charity. It aims to provide medical service to those who need it at rates within the reach of those in the lower salary brackets and to give reasonable remuneration to the doctors who provide the service. After much deliberation the M.M.A. Executive has approved a new scale of fees for general practitioners which is at least as high and in some cases higher than those of other provinces.[6] It is admitted that for the first year and possibly the second, it may not be possible for Manitoba Medical Service to pay 100% of the fees submitted by medical members, but the unpaid balance will remain as a contingent liability.

Admittedly Manitoba Medical Service is an experiment, but it is a co-operative experiment, and if approached in an atmosphere of good will it can be made to work. No by-law or contract of the plan is so rigid that it cannot be modified.

The purpose of medical men in society is to render medical service. If the public demands a change in the methods of rendering this service, it is entitled to be heard, provided that it is willing to ensure reasonable remuneration to the doctors. This is the basic principle underlying Manitoba Medical Service.

On behalf of the M.M.S. Board,

M. R. MacCharles,
H. D. Kitchen,
Ross Mitchell.

References:

1 Manitoba Medical Association, Annual Reports of Committees, June, 1941.
2 Manitoba Medical Association, Annual Reports of Committees, Sept., 1942.
3 Manitoba Medical Review, Ross Mitchell, Feb., 1943; E. S. Moorhead, Jan., 1944.
4 Canadian Medical Association Journal, Ross Mitchell, March, 1943, p. 241.
5 Manitoba Medical Association, Annual Reports of Committees, Sept., 1944.
6 Report of Committee of Economics, C.M.A. Journal, Vol. 51, p. 32, Sept., 1944.

♦

Manitoba Medical Services

The following decisions and regulations were made at a recent meeting of the Board of Trustees of the M.M.S. and by instructions of the Chairman are being published for the information of Medical Members:

THAT specialists may elect another specialized field in which to practise; the fee for such secondary specialty shall be that of a general practitioner.

THAT members of clinics be regarded as individual medical members with the privileges of medical members.

THAT infectious diseases should be covered except where care is available to the subscriber or his dependants without cost to him. In the case of a patient remaining at home for treatment, the attending physician would be reimbursed on the basis of the regular schedule of fees.

THAT since the Medical Service cannot restrict medical practice, examinations for sterility should be covered by the Plan.

THAT deep x-ray therapy will only be paid when done in a practitioner's office. The use of radium will not be paid for but the practitioner using it will be paid for his services. The Medical Service will not pay institutions.

THAT the doctor will be paid for innoculations, even if they are being done free by the municipality.

THAT when a patient is treated in a Hospital for Mental Diseases, it is not covered. If the patient is treated at the doctor's office, at home or in general hospitals, the medical care will be covered.

THAT x-ray of teeth will only be done when referred by a doctor to a doctor.

In view of the fact that many doctors may not have become familiar with the rules and regulations the Board will not enforce the penalty for late reports on October and November accounts. As from Dec. 31, 1944, accounts sent in after the 10th of each month will have a deduction of 5%. This is necessary for a satisfactory accounting system.

It is hoped that further regulations will be published from time to time, and also reports on the progress of the service.

E. S. Moorhead, M.B.,
Medical Director.

♦

Personal Notes and Social News

Major C. E. Corrigan, R.C.A.M.C. (Overseas) has been promoted to the rank of Lieut.-Colonel.

♦

Dr. and Mrs. J. T. Stirling announce the engagement of their only daughter, Florence Elizabeth, to John Pierce-Jones, eldest son of Mr. and Mrs. David Pierce-Jones of Slovang, California. The wedding to take place December 9th, in Winnipeg.

♦

Dr. E. H. Alexander is leaving Winnipeg December 18th to visit his wife and family at Vancouver where he expects to remain until the end of February.

♦

Lieut.-Colonel W. M. Musgrove, formerly officer commanding Fort Osborne Military Hospital, has been appointed District Medical Officer succeeding Colonel P. G. Bell.

♦

Captain William Burns MacKinnon, R.C.A.M.C., has been promoted to the rank of Major.

Department of Health and Public Welfare

Comparisons Communicable Diseases—Manitoba

(Whites Only)

DISEASES	1944 Oct. 8 to Nov. 4	1944 Sept. 10 to Oct. 7	1943 Oct. 10 to Nov. 6	1943 Sept. 12 to Oct. 9	TOTALS Jan. 1 to Nov. 4,'44	TOTALS Jan. 1 to Nov. 6,'43
Anterior Poliomyelitis	7	28	2	11	87	35
Chickenpox	161	33	197	41	1806	1376
Diphtheria	13	14	12	15	161	220
Diphtheria Carriers	2	6	3	1	27	23
Dysentery—Amoebic	----	----	----	----	----	7
Dysentery—Bacillary	1	30	2	3	62	18
Erysipelas	7	4	4	4	59	59
Encephalitis	1	1	1	2	10	11
Influenza	4	3	13	16	160	409
Measles	75	37	79	86	5214	2713
Measles—German	3	3	----	3	240	171
Meningococcal Meningitis	2	2	4	1	20	32
Mumps	9	15	115	75	1567	3331
Ophthalmia Neonatorum	----	----	----	----	----	----
Pneumonia—Lobar	7	----	8	10	130	152
Puerperal Fever	----	----	1	1	4	3
Scarlet Fever	77	62	149	83	1937	1241
Septic Sore Throat	----	----	1	1	22	40
Smallpox	----	----	----	----	----	----
Tetanus	----	----	1	----	1	2
Trachoma	----	----	----	1	----	3
Tuberculosis	41	43	53	46	508	513
Typhoid Fever	----	2	1	----	15	22
Typhoid Paratyphoid	----	----	----	----	----	3
Typhoid Carriers	----	----	----	----	1	2
Undulant Fever	1	1	1	----	6	10
Whooping Cough	46	38	84	87	356	1715
Gonorrhoea	152	126	126	137	1468	1426
Syphilis	54	53	60	43	564	468
Actinomycosis	----	----	----	----	2	1
Meningitis Carriers	----	----	----	----	----	6

DISEASE *Approximate Populations.	*738,000 Manitoba	*3,825,000 Ontario	*906,000 Saskatchewan	*2,972,300 Minnesota	*641,935 North Dakota
Actinomycosis	----	----	1	----	----
Anterior Poliomyelitis	7	36	3	87	2
Chickenpox	161	559	70	----	56
Diphtheria	13	25	22	75	10
Diphtheria Carriers	2	----	5	----	----
Dysentery—Amoebic	----	3	----	13	----
—Bacillary	1	----	1	----	7
Encephalitis Epidemica	1	----	----	1	2
Erysipelas	6	6	1	----	5
German Measles	3	37	10	----	----
Influenza	4	20	----	4	16
Malaria	----	----	----	----	2
Measles	77	174	47	9	3
Meningococcal Meningitis	2	6	----	14	3
Mumps	9	153	5	----	----
Ophthalmia Neonatorum	----	----	----	----	----
Puerperal Fever	----	----	----	----	----
Scarlet Fever	77	476	20	168	31
Septic Sore Throat	----	1	----	----	----
Smallpox	----	----	----	----	----
Trachoma	----	----	----	----	10
Tuberculosis	41	209	90†	13	12
Tularaemia	----	----	----	----	----
Typhoid Fever	----	4	1	----	----
Typhoid Fever Carriers	----	----	----	----	----
Typhoid Para-Typhoid	----	1	----	----	----
Undulant Fever	1	1	----	18	----
Whooping Cough	46	150	32	178	25
Gonorrhoea	152	441	----	----	19
Syphilis	54	374	----	----	15

†65 of these cases were reported from May to Sept.

DEATHS FROM COMMUNICABLE DISEASES

September, 1944

Urban—Cancer 50, Pneumonia (other forms) 8, Tuberculosis 7, Dysentery 5, Pneumonia Lobar 3, Influenza 1, Lethargic Encephalitis 1, Poliomyelitis 1, Syphilis 1, Malaria 1, Hydatid disease 1, Disease of pharynx and tonsils 1. Other deaths under 1 year 13. Other deaths over 1 year 203. Stillbirths 10. Total 306.

Rural—Cancer 29, Tuberculosis 23, Pneumonia (other forms) 8, Pneumonia Lobar 5; Syphilis 3, Diphtheria 1, Scarlet Fever 1, Whooping cough 1, Dysentery 1, Cerebrospinal meningitis 1. Other deaths under 1 year 34. Other deaths over 1 year 163. Stillbirths 15. Total 285.

Indians — Tuberculosis 13, Cancer 3‡, Measles 3, Pneumonia (other forms) 3, Pneumonia Lobar 1, Gonococcus infection 1. Other deaths under 1 year 6. Other deaths over 1 year 12. Stillbirths 3. Total 45‡.

‡White on Indian Reserve.

Anterior poliomyelitis incidence is decreasing as it should be, as its season is pretty well over.

Diphtheria is still much too prevalent.

Ophthalmia Neonatorum—Those zeros are nice to see.

Scarlet Fever morbidity may increase with the fall season.

Gonorrhoea and Syphilis are both increasing. All cases should be carefully treated, all sources and contacts should be traced, examined and treated if infected.

Venereal Disease Control

False Positive Serological Tests for Syphilis

False positive serological tests for syphilis may be divided into two categories; technical false positive reactions and biologic false positive reactions:

I. Technical False Positive Reactions

A. **Physician, Nurse or Orderly:**

1. Bacterial contamination and hemolysis:
   (a) non-sterile and wet syringes and test tubes,
   (b) improper storing of specimens,
   (c) delay in sending specimens to laboratory.
2. Mislabelling of specimens.
3. Accidental or intentional sending of oxalated or citrated specimens to the serodiagnostic laboratory.

B. **Laboratory:**

1. Dirty or improperly cleansed glassware.
2. Inexact measurements of the materials used in the test.
3. Faulty preparation or deterioration of the test materials.
4. Improper preparation of the serums.
5. Tests inadequately controlled or improperly read.
6. Mistakes in recording, copying and reporting the results of the tests.

The frequency of the occurrence of these technical false positive reactions is usually proportional to the care exercised in the performance of tests and the skill and experience of the individual performing them.

II. Syphiloid Diseases

Three diseases caused by spirochetes other than T. pallidum, namely, yaws, bejel, and pinta, will cause positive serological tests for syphilis. Yaws is endemic in all tropical countries. Bejel occurs particularly in Syria; and pinta in the West Indies, Mexico, and Central and South America. These diseases, which are quite similar bacteriologically, serologically, and in their response to anti-syphilitic treatment, may be designated as syphiloid or syphilislike conditions. The positive serological tests resulting from these conditions should not be considered as biological false positive reactions, but as confirmatory of the diagnosis of the diseases in question. In view of the world movement of Canadian Armed Forces personnel, interest in these diseases is pertinent.

III. Biological False Positive Reactions in Infectious Diseases Other Than Syphilis or Syphiloid Diseases

A. The most frequent of the diseases causing biological false positive serological tests and the approximate incidence of such tests in these various conditions is as follows:

1. **Vaccination against smallpox.** Ten to thirty-five per cent of persons with vaccine or vaccinoid reactions show false positive serological tests, these usually appearing about 12 days after vaccination, and persisting from several weeks to several months.

2. **Malaria.** The majority of malarial patients develop false positive serodiagnostic tests at some stage of the acute infection. In many instances the false positive tests persist for only a few days, but may persist for many months. The effect of long standing chronic malaria in producing persistent false positive tests is not yet evaluated.

3. **Pneumonia,** and upper respiratory infections. Due to micro-organisms or a virus, but particularly the latter, and other mild or severe upper respiratory infections, false positive reactions may be produced in 5 to 20 per cent of affected persons, these persisting for a few weeks to many months.

4. **Leprosy.** False positive reactions occur in from 60 to 70 per cent of affected persons and persist indefinitely.

5. **Infectious mononucleosis.** Transitory false positive reactions, lasting from a few days to several months, occur in about 20 per cent of affected persons.

6. **Other conditions,** in which false positive reactions may occasionally occur are typhus, Weil's disease, recurrent fever, rat-bite fever, chancroid, lymphogranuloma inguinale, mumps, and perhaps other acute infections.

B. The false positive reactions occurring in acute infections other than syphilis or syphiloid disease are usually weakly positive with a low serum reagin titre in quantitative tests. In general, and except in the case of leprosy, they tend to disappear spontaneously within 2 to 3 months after subsidence of the acute infection.

IV. Suggested Method of Evaluation of Suspected Biological False Positive Serological Tests for Syphilis

Evaluation of the occurrence of biological false positive tests for syphilis in non-syphilitic conditions requires the following procedure:

A. **A single positive** serological test for syphilis or even several positive tests on the same specimen in the absence of convincing history or clinical evidence of syphilis, should not be made the basis of a diagnosis.

B. **Repeated positive** tests on successive specimens, strong or weak, should not, without further evidence, be made the basis of a diagnosis of syphilis if

1. The person is febrile at the time of (or just before) testing.
2. Vaccination for smallpox has taken place within the 2 preceding months, especially with "take."
3. There is evidence of active or recent malaria, febrile respiratory tract infection, influenza, infectious mononucleosis, mumps, typhus, leprosy, or other diseases listed above.

C. **When such reasons for doubting** the specificity of serological test findings appear, antisyphilitic treatment should be withheld with repetition of the test every two weeks for 3 months. If the results remain positive or conflictingly positive and negative, the procedure described in (D) should, if possible, be carried through under expert direction.

D. **An examination to evaluate doubtful or conflicting serological** tests should include as much of the following data as can be obtained with available facilities:

1. An examination for stigmas of congenital syphilis, including such x-ray examinations as may be required, inspection of the ocular fundi, and slit-lamp examination of the cornea.
2. Additional serological tests for syphilis utilizing several laboratory procedures if available.
3. Serological tests or credible information thereon regarding parents, siblings, marital or sexual partners, and children, as obtainable.
4. Serially repeated reagin unit titre determination on positive bloods by an accepted quantitative procedure if available.
5. Examination of the blood for plasmodia.
6. Differential blood count (infectious mononucleosis).
7. A heterophile antibody test.
8. If the patient is febrile, repeated blood cultures, x-ray of chest, other appropriate evaluative procedures.
9. An examination of the spinal fluid.
10. The so-called "provocative" injection of an arsenical drug is useless and should not be employed.

E. If, in the opinion of an expert, the results of such an examination are inconclusive, the individual should not be treated for syphilis. Further observation and investigation, including repetition of the serological and laboratory studies, excluding the spinal fluid examinations, in 6 months and the entire laboratory study after 1 year is advised.

(Material in above article submitted by Venereal Disease Central Division of the Department of National Health and Welfare, Ottawa.)

Overseas Letter (Continued from Page 358)

Capt. Max Secter and Major Lou Boxer are all just a few miles down the road at a 200-bed hospital and appear to be enjoying life. Major Fred Walton is anaesthetist at the same place. Major Ian McLean is very disgruntled these days having fairly recently been saddled with the job of running a station hospital at base. Ed. Corrigan, as you probably know, has an ambulance now. He was in a few days ago boasting an additional half-inch curl on his "Marshall Budenny" model face piece. When last heard of the remaining Winnipeg members of No. 5 were all in good health and spirits. Roy Richardson, incidentally, has not grown any more staid with his increased responsibilities. Major John Gonshorn is making a name for himself in these parts as a surgeon of note — doing some excellent work in 5 C.C.S. Capt. Max Lerner has been with an infantry battalion for some months now and rumor hath it that as long as he can inveigle a few gullible souls into his R.A.P. to play a quiet game of stud, draw a black jack a couple of times a week he has no need to visit the paymaster. Capt. Steve Warobitz is now also an R.M.O. with the infantry and Capt. John Gemmil with an artillery regiment. Capt. "Slug" Luginsky — I can't remember his Christian name — was with the infantry for nearly a year and is now in an F.D.S. Capt. Joe Brook is with a field ambulance and is to my certain knowledge the only officer who has served continuously forward of or at an A.D.G. ever since we landed in Sicily, which is some sort of a record, but not the sort that very many aspire to in these parts these days. In fact, this would fall in the classification of "greatness that is thrust upon one." Capt. John Poole is O.C. of a transfusion unit and bearing up under the responsibilities and administrative burdens pertaining thereto remarkably well. Major Harold Gislason is in an F.D.S. George Black—known as "Don" in his intern days, I believe, is at 15 General as is Lazerick (both Capts.). Harry Fahrni is at 14 General, where Wigglesworth is pathologist. Wiggie, incidentally, married a nursing sister not so long ago. Buss Bell would probably be interested to hear that if he has not already heard of it. Capt. Joe Portnuff has recently joined one of the first div. ambulances and Capts. Hugh Alan, Bob Meyer and Don Grant are all with light field ambulance.

Everyone out here has been most appreciative of the way the Associations as home have kept us posted on the medical-political situation and I think I can safely add that most of us while, again appreciating the fact that we were being given the opportunity to express our views in the questionnaire last winter, felt a bit diffident about completing them at this distance in time and miles.

Sincerely,

Paul K. Tisdale.

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